

Issued: 03/98

**Appendix 11a**  
**Prior Authorization Spell of Illness Attachment**  
**Completion Instructions**

Do not use this attachment to request prior authorization (PA) to extend treatment beyond 35 treatment days for the same spell of illness; use the Prior Authorization Therapy Attachment (PA/TA).

Timely determination of PA is significantly increased by submitting thorough documentation when requesting PA for a spell of illness. Carefully complete the Prior Authorization Spell of Illness Attachment (PA/SOIA) form, attach it to the Prior Authorization Request Form (PA/RF), and submit to:

Prior Authorization, Suite 88  
EDS  
6406 Bridge Road  
Madison, WI 53784-0088

Questions regarding the completion of the PA/RF and/or PA/SOIA may be directed to the fiscal agent's Policy/Billing Correspondence Unit. Telephone numbers are in Appendix 2 of Part A, the all-provider handbook.

*Recipient Information:*

**Element 1 - Recipient's Last Name**

Enter the recipient's last name from the recipient's current identification card.

**Element 2 - Recipient's First Name**

Enter the recipient's first name from the recipient's current identification card.

**Element 3 - Recipient's Middle Initial**

Enter the recipient's middle initial from the recipient's current identification card.

**Element 4 - Recipient's Wisconsin Medicaid Identification Number**

Enter the recipient's 10-digit identification number from the recipient's current identification card.

**Element 5 - Recipient's Age**

Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

*Provider Information:*

**Element 6 - Therapist's Name and Credentials**

Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter his/her name and credentials, also enter the name of the supervising therapist.

**Element 7 - Therapist's Wisconsin Medicaid Provider Number**

Enter the eight-digit provider number of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her provider number, also enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

**Element 8 - Therapist's Telephone Number**

Enter the telephone number, including area code, of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her telephone number and the telephone number of the supervising therapist.

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**Element 9 - Referring/Prescribing Physician's Name**

Enter the name of the physician referring/prescribing evaluation/treatment.

**Part A**

Enter an "X" in the appropriate box to indicate a physical, occupational, or speech therapy spell of illness request.

**Part B**

Enter a description of the recipient's diagnosis and problems. Indicate what functional regression has occurred and what the potential is to reach the previous skill.

**Part C**

Attach a copy of the recipient's Therapy Plan of Care, including a current dated evaluation, to the Spell of Illness attachment before submitting the spell of illness request.

**Part D**

Enter the anticipated end date of the spell of illness in the space provided.

**Part E**

Attach the physician's dated signature on either the Therapy Plan of Care or the copy of the physician's order sheet. Read the 'Prior Authorization Statement' before signing and dating the attachment.

**Part F**

The signature of the prescribing physician and the date must appear in the space provided. (A signed copy of the physician's order sheet is acceptable.)

**Part G**

The dated signature of the therapist providing evaluation/treatment must appear in the space provided.